Australian Government
Aged Care Quality and Safety Commission

Engage
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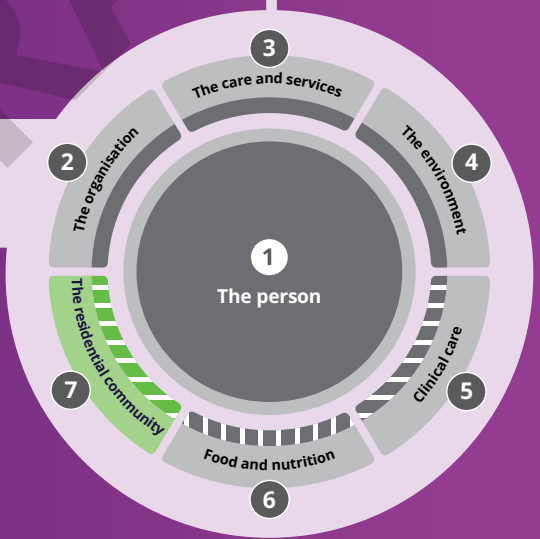
Draft **Standard 7 The Residential Community**

Guidance material for the strengthened Aged Care Quality Standards for review and discussion



January 2024

7

Contents

Please note the draft strengthened Quality Standards in this document are not yet in operation. This draft is intended for consultation purposes only.

Purpose of the guidance

The Aged Care Quality and Safety Commission is committed to supporting the aged care sector to be ready for the implementation of the strengthened Aged Care Quality Standards.

This draft guidance material is intended to support providers to comply with the strengthened Quality Standards. It also aims to promote best practice in service provision.

Aged care services vary in size and structure and have different ways of meeting the Standards. The draft guidance shows how providers can demonstrate they meet each Standard outcome.

This material is not a prescriptive guide. When we assess provider conformance against the Aged Care Quality Standards we won't expect that every provider will necessarily be taking each of the described actions. The actions you take to deliver high quality safe care will depend on the circumstances of your service and the needs of the people in your care. The material in this document can be used as a guide to achieving quality care outcomes in your organisation.

Consultation

We are consulting on the draft guidance materials for providers that deliver government-funded aged care services. Your insights will help to make our guidance materials:

- fit for purpose across service types
- practical and easy to understand
- useful tools for continuous improvement

We invite you to consider the below questions when reading through this document:

- Have you read and understood the draft Guidance material for the strengthened Quality Standard?
- To what extent do you feel the draft Guidance is fit-for-purpose for the different service types you deliver?
- To what extent do you feel the draft Guidance easy to understand and interpret?
- Is the level of detail in the Guidance right for each Outcome or Action? Is there content missing in relation to any Outcome or Action? Please specify the Outcome and Action and tell us what you would like changed.

You can provide your feedback by filling in this feedback form or using the QR code on this page before midday (AEST) on 30 April 2024.

Questionnaire
https://survey.websurveycreator.com/s/ConsultationStrengthenedQualityStandardsMaterial

Structure of this document

The guidance material is intended to help support delivery or person centred quality care and outcomes. It presents the intent and outcomes of the strengthened Standard including key concepts.

The tables on the following pages outline how you can achieve these outcomes in practice, depending on your role within an organisation.

To help users easily find information that applies to their service role, there are separate tables for:

- Governing body
- Provider organisation
- Worker (when applicable)

Different colour bars at the top of the tables indicate who in your organisation the information is targeted for.

Each of the tables include suggested actions and activities that can help achieve the outcomes of the strengthened standards and support continuous improvement.

We are also developing examples and other key resources that can be used as a further guide to ensure best practice in person-centred care. These will be made available at a later stage.

Guidance on Standard 7: The Residential Community

What is the intent?

When people move into a residential service, the residential community becomes a central feature of their lives. It is critical that older people feel safe and at home in the residential community, have opportunities to do things that are meaningful to them and are supported to maintain connections with people important to them.

Meaningful activities can include participating in hobbies or community groups, seeing friends and family or activities that contribute to the residential community such as gardening, cooking and setting tables.

A residential community can involve diverse members from different cultures and backgrounds. It is important that each older person's culture is respected, and their diversity valued so they feel included, safe and at home in the service.

Given the scope of responsibility in residential care, providers also have increased requirements to ensure that older people have access to other services and to coordinate a planned transition to or from the service to maximise continuity of care.

Standard 7 is intended to apply only to residential care services or providers registered under Category 6.

What will older people say if you are achieving the outcomes of this standard?

"I am supported to do the things I want and to maintain my relationships and connections with my community. I am confident in the continuity of my care and security of my accommodation."

What are the key concepts?

The following key concepts are covered by Standard 7 The Residential Community:

Outcome 7.1 Daily living	Outcome 7.2 Transitions
Activities of daily living	Activities of daily living
Dignity of risk	Continuity of care *
Physical and psychological safety *	Informed consent
Quality of life	Privacy *
Security *	Transitions of care
Choice *	
Access *	

* A full list of key terms and definitions for the strengthened Quality Standards can be found in the Glossary of Terms and Definitions.

Guidance for Outcome 7.1: Daily living

What is the Outcome that needs to be achieved?

Older people receive services and supports for daily living that optimise their quality of life, promote use of their skills and strengths and enable them to do the things they want to do.

Older people feel safe in their service environment.

Why is this Outcome important?

Outcome 7.1 explains how important it is to provide older people with services and supports for daily living. As a provider, you need to know that the care and services you deliver have an impact on older people's physical and psychological well-being.

The following key concepts have been strengthened:

- minimising boredom and loneliness
- monitoring older people's function in relation to activities of daily living
- strategies to protect the physical and psychological safety of older people
- entertaining visitors in private
- making sure older people can engage in sexual activity without judgement.

How can you achieve Outcome 7.1 in practice?

Governing body	
Actions	**Associated activities**
7.1.1 The provider supports and enables older people to do the things they want to do, including to: a) participate in lifestyle activities that reflect the diverse nature of the residential community b) promote their quality of life c) minimise boredom and loneliness d) maintain connections and participate in activities that occur outside the residential community e) have social and personal relationships f) contribute to their community through participating in meaningful activities that engage the older person in normal life.	**Monitor the provider organisation's performance. You need to make sure older people get services and support that are important for their health and well-being.** The governing body: • Is accountable for the organisation's delivery of quality care and services (Outcome 2.2 and Outcome 2.3). • Needs to maintain oversight of all aspects of operations by reviewing the provider organisation's reports. Reports will describe the: – Delivery of support and activities of daily living. – Management of complaints, feedback and incidents (Outcome 2.5 and Outcome 2.6). – The quality of care and services delivered by workers (i.e., performance assessments). • Must lead a culture of safety, inclusion and quality in care and services. This is done by monitoring and investigating priority areas found in the reports listed above. If the governing body finds any issues or ways the provider can improve through these reviews, the governing body needs to address them. The governing body needs to provide feedback and support to the provider to be able to improve. If things go wrong, the governing body needs to: • Practice open disclosure. This means being open about what has gone wrong and sharing this information with older people, their family and carers. • Implement strategies to mitigate the risk of things going wrong again. Further detail on this can be found at Outcome 2.3. When monitoring the provider organisation's performance, this needs to include monitoring the performance of any subcontracted providers.
7.1.2 The provider has processes to identify, monitor and record older people's function in relation to activities of daily living.	
7.1.3 The provider implements strategies to protect the physical and psychological safety of older people.	
7.1.4 Older people have control over who goes into their room and when this happens.	
7.1.5 Older people can entertain their visitors in private.	
7.1.6 Older people can maintain relationships of choice free from judgement, including intimate relationships, and engage in sexual activity.	

Provider organisation	
Actions	**Associated activities**
7.1.1 The provider supports and enables older people to do the things they want to do, including to: a) participate in lifestyle activities that reflect the diverse nature of the residential community b) promote their quality of life c) minimise boredom and loneliness d) maintain connections and participate in activities that occur outside the residential community e) have social and personal relationships f) contribute to their community through participating in meaningful activities that engage the older person in normal life.	**Make sure the assessment and planning system for delivering care and services support a community experience. This needs to be in line with older people's needs and preferences (Outcome 3.1 and Outcome 3.2).** This system needs to tailor supports to each older person, so they can: • Do the things they want to do, both inside and outside the residential community. For example, you can support them by providing transport to activities outside the residential community. • Take part in activities they are interested in. Activities can be individual, group, or partnered. This helps to: – Promote emotional, spiritual, and psychological well-being. – Maintain independence, in line with their goals and preferences. – Minimise boredom and loneliness. – Maintain relationships inside and outside the residential community. • Contribute to the community in ways they want to. For example, this can be by helping with gardening or decorating common areas. • Be involved in the selection of strategies that protect their physical and psychological safety (Outcome 5.4 and Outcome 4.1(b)). • Maintain their privacy. This is done by understanding who can enter their room, without feeling unsafe. Also, by understanding when people and visitors can enter their room. You need to make sure the personal privacy of older people is respected (Outcome 1.2). Any activities, strategies, or supports for individuals needs to be documented within care and services plans. You need to review and improve these plans with older people (Outcome 3.1). Care and services need to be delivered in a way that: • Meets older people's needs, goals and preferences. For example, if an older person wants to help maintain their cognitive function, you need to make sure they are provided with tasks that help them do this. Such tasks can include crosswords. • Optimises their quality of life. For example, if an older person is happier spending time outside, you need to help them do things outside (such as gardening or reading). • Helps older people do what they want to do. For example, workers need to be available to support an older person to go for a walk if this is something they enjoy. • Regains and keeps physical and mental function by promoting use of their skills and strengths. For example, if an older person enjoys reading, you can provide them with books. • Is culturally safe and appropriate for people with diverse backgrounds (Outcome 3.2). *Continued on the next page*
7.1.2 The provider has processes to identify, monitor and record older people's function in relation to activities of daily living.	
7.1.3 The provider implements strategies to protect the physical and psychological safety of older people.	
7.1.4 Older people have control over who goes into their room and when this happens.	
7.1.5 Older people can entertain their visitors in private.	
7.1.6 Older people can maintain relationships of choice free from judgement, including intimate relationships, and engage in sexual activity.	

Provider organisation (continued)	
Actions	**Associated activities**
	You also need to monitor and record older people's physical and cognitive functions during and after they take part in activities of daily living. This needs to be performed with older people, and with their informed consent where relevant. You can integrate this process with comprehensive care actions you may need to take (Outcome 5.4). Strategies you develop need to support an older person's daily living and need to be in line with the delivery of tailored care for older people (Outcome 1.1, Outcome 1.2 and Outcome 1.3). In particular, you need to: • Support older people's choice and decisions to take risks (Outcome 1.3). This includes supporting older people with activities of daily living. For example, older people cannot be forced to go for a walk or participate in group activities if they do not want to. • Recognition and respect of the rights and autonomy of older people. This includes their right to intimacy, sexual and gender expression. For example, you must make sure older people are supported to spend time with whoever they want and respect their privacy **Make sure workers have the time, support, and resources to encourage and support older people to perform activities of daily living.** Develop and follow a workforce strategy to assess workers' abilities during the hiring process (Outcome 2.8). You also need to provide workers with guidance and training on how to support activities of daily living and optimise quality of life. Training needs to be in line with: • The organisation's policies and procedures. • Their roles and responsibilities (Outcome 2.9). You should consider whether specialist roles such as allied health or other health professionals are needed. You can find more information in the guidance material for Standard 2 (Outcome 2.9). **Monitor how you plan for and deliver care and services to make sure older people get the services and supports for daily living.** To understand if older people are getting the services and support for daily living, you need to review: • Older people's care and service plans, including progress notes (Outcome 3.1). • Whether older people are bored or lonely, and if the activities of daily living meet their needs. • Complaints (Outcome 2.6). • Feedback (Outcome 2.6). • Incident information (Outcome 2.5). *Continued on the next page*

Provider organisation (continued)	
Actions	**Associated activities**
	You need to use the outcomes of your review to: • Improve support for daily living to optimise older people's quality of life. • Understand if community activities and the environment are safe. This includes checking they are culturally safe. • Understand if older people's family and friends feel comfortable to visit the residence. • Understand if older people can maintain a level of privacy in their rooms that does not make them feel unsafe. You also need to assess whether workers are following your quality management system when delivering services and support for daily living (Outcome 2.9). You can do this through performance assessments and system checks. If you find issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, you need to be open about it and share this information with older people, their family, and carers. You will know things are going well if older people say that they feel supported to: • Do the things they want to do. • Maintain their relationships and connections with the community. Additional indicators should be used to monitor older people's behaviours to identify issues and improvement opportunities for the residential environment. You can find more information on monitoring the quality management system in the guidance material for Standard 2 (Outcome 2.3).

Worker	
Actions	**Associated activities**
7.1.1 The provider supports and enables older people to do the things they want to do, including to: a) participate in lifestyle activities that reflect the diverse nature of the residential community b) promote their quality of life c) minimise boredom and loneliness d) maintain connections and participate in activities that occur outside the residential community e) have social and personal relationships f) contribute to their community through participating in meaningful activities that engage the older person in normal life.	**Maintain a community experience for older people in line with their needs and preferences. This should happen during assessment and planning and when delivering care and services (Outcome 3.1 and Outcome 3.2).** You support the older person to: • Do the things they want to do, both inside and outside the residential community. For example, you can support them by providing transport to do activities outside the residential community. • Take part in individual, group and partnered activities they are interested in. The support they provide needs to help older people to: – Promote emotional, spiritual, and psychological well-being. – Maintain independence, in line with their goals and preferences. – Minimise boredom and loneliness. – Create new and maintain relationships inside and outside the residential community. • Contribute to the community in ways they want to. For example, this can be by helping with gardening or decorating common areas. • Be involved in the selection and putting in place strategies that protect their physical and psychological safety (Outcome 5.4 and Outcome 4.1(b)). In line with Outcome 1.1, Outcome 1.2 and Outcome 1.3, you need to: • Deliver care and services in a way that optimises the older person's quality of life. You do this by helping older people to regain and keep their physical and mental function in line with their preferences (Outcome 3.2 for more detail). This means promoting older people to use of their skills and strengths. Older people need to get your help to do the things they want to do. • Document activities, strategies, and support for the older person within care and services plans. You need to review and improve these plans with older people (Outcome 3.1). • Monitor and record older people's physical and cognitive functions during and after the activities they take part in. This needs to be done with older people, and with their informed consent where relevant (Outcome 5.4). • Recognise and respect the rights and autonomy of older people. This includes their right to intimacy, sexual and gender expression. • Ensure choice is respected and that dignity in risk is maintained. In particular, dignity of risk must be maintained when supporting older people with activities of daily living. *Continued on the next page*
7.1.2 The provider has processes to identify, monitor and record older people's function in relation to activities of daily living.	
7.1.3 The provider implements strategies to protect the physical and psychological safety of older people.	
7.1.4 Older people have control over who goes into their room and when this happens.	
7.1.5 Older people can entertain their visitors in private.	
7.1.6 Older people can maintain relationships of choice free from judgement, including intimate relationships, and engage in sexual activity.	

Worker (continued)	
Actions	**Associated activities**
	Respect the privacy of older people when providing care and services (Outcome 1.2). You need to: • Give older people control over who goes in their room and when. • Help older people to entertain their guests in private. • Support an older person's privacy if they share a room. • Help older people to maintain relationships of choice free from judgement. This includes intimate relationships and sexual activities. • Provide feedback to management about how the privacy of older people can be better maintained.

What are the key resources that can be referred to?

The following key resources relate to Outcome 7.1:

- [TO BE COMPLETED]

Key legislation relevant to this outcome includes:

- [TO BE COMPLETED]

Other provider obligations include:

- [TO BE COMPLETED]

The content for this page is still under development and will be included in the final versions of the Guidance material.

Guidance for Outcome 7.2: Transitions

What is the Outcome that needs to be achieved?

Older people experience a well-coordinated transition to or from the provider for planned and unplanned transitions. There is clear responsibility and accountability for an older person's care and services between workers, health professionals and across organisations.

Why is this Outcome important?

Transitions of care are a key risk for older people and effective care coordination is needed during these circumstances. They are typically around times when an older person's needs and preferences change.

Outcome 7.2 explains why continuity of care is important. This is when older people transition between residential care, other places providing care and services and stays in the community.

The following key concepts have been strengthened:

- Continuity of care.
- Facilitating access to other services if needed.
- Maintaining connections with specialist services.

How can you achieve Outcome 7.2 in practice?

Governing body	
Actions	**Associated activities**
7.2.1 The provider has processes for transitioning older people to and from hospital, other care services and stays in the community, and ensures that: a) use of hospitals or emergency departments are recorded and monitored b) there is continuity of care for the older person c) older people, their families and carers as appropriate, are engaged in decisions regarding transfers d) receiving family, carers, health professionals or organisations are given timely, current and complete information about the older person as required e) when the older person transitions back to the service, their care and services are reviewed and adjusted as needed.	**Monitor the provider organisation's performance in transitioning older people to get the care and services they need.** The governing body: • Is accountable for the organisation's delivery of quality care and services (Outcome 2.2 and Outcome 2.3). • Needs to maintain oversight of all aspects of their operations by reviewing the organisation's reports on the: – Management of complaints, feedback and incidents (Outcome 2.5 and Outcome 2.6). – Quality of care and services delivered by workers (i.e., performance assessments) (Outcome 2.9). Governing bodies need to make sure transitions happen in way which promotes continuity of care. • Leads a culture of safety, inclusion and quality. This is done by monitoring and investigating priority areas found in the reports listed above. If the governing body finds any issues or ways the provider can improve through these reviews, the governing body needs to address them. The governing body needs to provide feedback and support to the provider to be able to improve. If things go wrong, the governing body needs to: • Practice open disclosure. This means being open about what has gone wrong and sharing this information with older people, their family and carers. • Implement strategies to mitigate the risk of things going wrong again. Further detail on this can be found at Outcome 2.3. When monitoring the provider organisation's performance, this needs to include monitoring the performance of any subcontracted providers.
7.2.2 The provider facilitates access to services offered by other individuals or organisations when it is unable to meet the older person's needs.	
7.2.3 The provider maintains connections with specialist dementia care services and accesses these services as required.	

Provider organisation	
Actions	**Associated activities**
7.2.1 The provider has processes for transitioning older people to and from hospital, other care services and stays in the community, and ensures that: a) use of hospitals or emergency departments are recorded and monitored b) there is continuity of care for the older person c) older people, their families and carers as appropriate, are engaged in decisions regarding transfers d) receiving family, carers, health professionals or organisations are given timely, current and complete information about the older person as required e) when the older person transitions back to the service, their care and services are reviewed and adjusted as needed.	**Develop and implement processes for transitioning older people.** You need to find and record all relevant information when an older person is transferred. Transfers can happen between: • Locations • Provider organisations • Providers of care and services • Levels of care within the same location or as the older person's condition and care needs change. To make sure there is continuity of care, your transition processes need to: • Involve the use of your communication system (Outcome 3.3). • Include processes to plan and coordinate transition of care and services before a decision is made (Outcome 3.4 and Outcome 5.4). This happens with the older person, their family, carers, and other providers of care and services. It also applies to other residential care providers and home care providers. You must make sure all parties are clear on their responsibilities and accountabilities. • Consider each older person's identity, culture, ability, diversity, beliefs and life experiences. This information is in their care and services plans and is established with the older person (Outcome 1.1). For example, an older person may have a connection with a particular health service they would like to transition to. • Help workers and others caring for an older person to have access to the older person's current medication, medical equipment and other supporting information (Outcome 5.3 and Outcome 5.4). This information needs to be reviewed before the transition happens. It also needs to be current, complete, and provided in a timely manner. Your information management system and clinical information system needs to make sure the privacy of older people is in accordance with data security requirements (Outcome 2.7). • Record and monitor older people's hospital or emergency department visits. You also need to assess and record any changes to older people's care and services plans, when they transition back to your care (Outcome 2.7). • Be in line with comprehensive care needs (Outcome 5.4). You need to: – Make sure hospital discharge and transfer summary information is considered and reviewed. This is to inform changes to older people's care and services in a timely manner. You need to make sure information is accurate. You can do this by actively partnering with people who provide care and services to the older person. – Make sure medication reviews are conducted at the time of any transition. – Monitor clinical conditions. You need to increase monitoring and observation of an older person in the days following their transition from hospital. *Continued on the next page*
7.2.2 The provider facilitates access to services offered by other individuals or organisations when it is unable to meet the older person's needs.	
7.2.3 The provider maintains connections with specialist dementia care services and accesses these services as required.	

Provider organisation (continued)	
Actions	**Associated activities**
	– Review goals with consideration given to reablement with the older person. This means, trying to help the older person to regain their physical and mental function. – Evaluate the effectiveness of the older person's care and services plan. Update their plan as needed. – Store, manage, use, and share advance care planning documents with relevant parties, if relevant (Outcome 5.4). • Use your risk management system when planning transitions (Outcome 2.4). You need to consider: – Transitions at night. This is because it will have additional considerations and risks. For example, low-light situations and impact to sleeping patterns. – Scenarios where the safety of the older person is in an uncontrolled environment. For example, when discharged from hospitals by family members. You also need to consider the processes in place if things go wrong in uncontrolled environments. **Develop and implement strategies to help older people access care and services when they need or want to.** As part of comprehensive care, there are services that are needed to address individual older person's clinical needs (Outcome 5.4). These can be medical, rehabilitation, allied health, palliative care, specialist nursing and advisory services. For example, specialist dementia care services. You need to give comprehensive care once you understand older people's individual needs (Outcome 5.4). This means, you need to address these needs and minimise the risk of harm (Outcome 5.5). Your strategies need to make sure that you help older people get the specialist support they need. For example, specialist support can be to: • Maintain oral health • Manage pain • Manage wounds • Access palliative and end-of-life care • Support mental health • Maximise mobility • Manage sensory and/or cognitive impairment • Manage dementia. Where needed, you need to keep connections with specialist services so that older people can get to timely support when they need it. *Continued on the next page*

Provider organisation (continued)	
Actions	**Associated activities**
	Make sure workers who provide care and services have the time, support, and resources to use your processes for transitions. You need to develop and follow a suitable workforce strategy. Your strategy needs to consider transitions of care and has to assess workers' abilities during the hiring process (Outcome 2.8). You also need to provide workers with guidance and training on how to manage transitions of care in line with: • Your organisation's policies and procedures. • Their roles and responsibilities (Outcome 2.9). You can find more information in the guidance material for Standard 2. **Monitor the implementation and effectiveness of your processes for transitions of care.** To understand if you are managing transitions of care appropriately, you need to review: • Feedback (Outcome 2.6). • Older people's care and service plans as well as progress notes (Outcome 3.1). • Complaints (Outcome 2.6), • Incident information (Outcome 2.5). You also need to assess whether workers are following your quality management system (Outcome 2.9). You can do this through performance assessments and system checks. If you find any issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, you need to be open about it and share this information with older people, their family, and carers. You will know things are going well if older people say that they are confident in the: • Continuity of their care. • Security of their accommodation. You can find more information on monitoring the quality management system in the guidance material for Standard 2 (Outcome 2.3).

Worker	
Actions	**Associated activities**
7.2.1 The provider has processes for transitioning older people to and from hospital, other care services and stays in the community, and ensures that: a) use of hospitals or emergency departments are recorded and monitored b) there is continuity of care for the older person c) older people, their families and carers as appropriate, are engaged in decisions regarding transfers d) receiving family, carers, health professionals or organisations are given timely, current and complete information about the older person as required e) when the older person transitions back to the service, their care and services are reviewed and adjusted as needed.	**Use the processes for transitioning older people to and from hospital, other care services, and stays in the community.** You need to use these processes in any situation when all or part of an older person's care is transferred. Transfer can happen between: • Locations • Organisations • Providers • Levels of care within the same location, or as the older person's condition and care needs change. Depending on your role, this can include activities to make sure there is continuity of care. You may need to: • Use of the organisation's communication system (Outcome 3.3). • Plan and coordinate transitions with the older person and other providers of care and services (Outcome 3.4 and Outcome 5.4). You need to engage with the older person, their family, and any carers in decisions about transitions. You need to be clear about all parties agreed responsibilities and accountabilities. • Facilitate transitions in a way that is culturally safe. This means, you need to consider each older person's identity, culture, ability, diversity, beliefs and life experiences. This is in line with the older person's needs and preferences in their care and service plans (Outcome 1.1). For example, this can include making sure an older person with a connection to a particular health service is able to access that service when needed. You can do this by providing transport or other support. • Help other workers and others caring for an older person to access and record important information. This information can be the older person's current medication, medical equipment, and other supporting information (Outcome 5.3 and Outcome 5.4). You need to make sure that all information is current, complete, and provided in a timely manner. You need to use the provider organisation's information management system and clinical information system in line with legal requirements (Outcome 2.7 and Outcome 5.1). This is about making sure older people's data and information is secure, private, as well as obtained and shared with older people's consent. • Record and monitor older people's hospital or emergency department visits. This is to capture any relevant changes to their care and services plan, upon transitioning back to the provider organisation's care (Outcome 2.7). • Capture and enter information to the clinical information system (Outcome 5.1). You need to enter information into My Health Record, so other health professionals who provide care and services have access to information relevant to them. *Continued on the next page*
7.2.2 The provider facilitates access to services offered by other individuals or organisations when it is unable to meet the older person's needs.	
7.2.3 The provider maintains connections with specialist dementia care services and accesses these services as required.	

Worker (continued)	
Actions	**Associated activities**
	• Deliver comprehensive care (Outcome 5.4). You do this by: – Making sure hospital discharge and transfer summary information is considered and reviewed. This is to inform changes to older people's care and services in a timely manner. You need to make sure information is accurate. You can do this by actively partnering with people who provide care and services to the older person. – Make sure medication reviews are conducted at the time of any transition. – Monitor clinical conditions. – Assess the effectiveness of the older person's care and services plan. Update the plan as needed. – Store, manage, use, and share advance care planning documents with relevant parties, if relevant. • Use the controls for planned transitions found in the risk management system (Outcome 2.4). You need to consider: – Transitions at night. This is because it will have additional challenges. For example, low-light situations and impact to sleeping patterns. – Scenarios where the safety of the older person is in an uncontrolled environment. For example, when discharged from hospitals by family members. You need to consider the processes in place if things go wrong in those scenarios. **Use strategies to help older people access care and services when they need or want to. For example, dementia specialists or allied health care providers.** Depending on your role, you may need to: • Understand the specialist services that are needed to help each older person's clinical needs (Outcome 5.4). Specialist services and support can be medical, rehabilitation, allied health, specialist nursing and advisory services. • Help older people get the specialist support they need (Outcome 5.5). For example, this can be access to specialists who can support the older person with: – Management of oral health – Management of pain and wounds – Palliative and end-of-life care – Support mental health – Maximise mobility – Manage sensory or cognitive impairment, and/or dementia.

What are the key resources that can be referred to?

The following key resources relate to Outcome 7.2:

- [TO BE COMPLETED]

Key legislation relevant to this outcome includes:

- [TO BE COMPLETED]

Other provider obligations include:

- [TO BE COMPLETED]

The content for this page is still under development and will be included in the final versions of the Guidance material.

The Aged Care Quality and Safety Commission acknowledges the Traditional Owners of country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to Elders both past and present.

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